A. OVERVIEW

Long-term care (LTC) programs provide services for the elderly and disabled in need of institutional care. Some clients who receive LTC services are able to continue living in their home or in an **alternate living facility** (ALF). Home and community-based services, provided under a Medicaid waiver granted by the federal government, enable them to live in a residential setting outside of a nursing or other medical facility or in their own home. Such services are referred to as **waivered services**. Others require **institutional services** that can be provided only in a medical facility. Some clients receive **hospice services** in addition to or instead of services in their home or a medical facility. All clients approved for any of the LTC services described in this section have attained **institutional status** and are considered to be **institutionalized** as described in Medicaid law and the regulations used to implement these programs.

The department must determine a client's eligibility for LTC services according to both functional and financial requirements. A department-designated social worker establishes functional eligibility; some of their responsibilities are described in this chapter. A financial services specialist (FSS) uses the rules and procedures described in this chapter to establish a client's financial eligibility and participation in the cost of care. The amount of income and resources a client must contribute to the cost of care for services received is established in what is called the post-eligibility determination.

This chapter also describes the rules and procedures used to determine a client's eligibility for non-institutional medical assistance provided in an ALF. Some clients require the assistance provided in such a facility, but do not require the additional services provided under an LTC program. The financial standards used to determine eligibility for non-institutional medical assistance in an ALF are based on the department-contracted rate and the private rate of the facility in which the client lives.

When determining eligibility and the cost of care for LTC services, program policy requires an allocation of income and resources from the institutionalized spouse to the community spouse. For purposes of these allocations, the distinction is made throughout this chapter between an institutionalized spouse, who is applying for or receiving LTC services, and a community spouse, who is not, when eligibility and participation in the cost of care for these services is determined. The Medicare Catastrophic Care Act in 1988 began the spousal allocation process used to discourage the impoverishment of a spouse due to the need for LTC services by their husband or wife. That law and those that have extended and/or amended it are referred to as spousal impoverishment legislation.

The rules used to determine eligibility and participation costs for waivered services are similar to those for institutional services, but there are important differences. These

differences, in addition to those related to hospice services, are discussed when the rules that describe them are covered in this section.

A client may be eligible for both medical assistance and institutional services, or be eligible for one but not the other.

Responsibilities and Program Administration

Community Services Offices (CSO) staff determine financial eligibility for the following long-term care (LTC) clients:

- Division of developmental disabilities (DDD) clients receiving LTC services paid for by DDD
- Mental health clients receiving LTC services paid for by Mental Health/ Regional Support Network (MH/RSN)
- Coordinated community AIDS services alternatives (CASA) clients receiving services from the department of health (DOH)
- Drug and Alcohol Substance Abuse (DASA) clients receiving LTC services paid for by DASA
- Households receiving temporary assistance for needy families (TANF) or state family assistance (SFA) (including children's medical only) financial or medical benefits that include an LTC client

Home and community services (HCS) staff determine financial eligibility for all other LTC clients who receive the following services:

- Nursing facility (NF) care
- COPES services
- Assisted living services
- Adult family home service
- Medicaid personal care services
- Adult residential care services
- Chore services
- Food stamp program eligibility (associated with LTC Services) when the non-LTC clients in the household do not receive TANF or SFA (including children's medical only) financial or medical benefits
- General assistance (GA) for clients receiving services paid for by the Adult and Aging Services Administration (AASA)

Financial staff determine financial eligibility by comparing the client's income, resources, and circumstances to program requirements. The HCS social worker (SW), the DDD or DOH case manager (CM), or the Veterans Affairs registered nurse (VARN) determines functional eligibility according to the particular program and place of residence and authorizes the services that are appropriate for the plan of care. Both financial and functional eligibility must be established concurrently. Coordination between financial and social service staff is required to process applications and provide services. Financial staff determine eligibility for non-institutional medical assistance at the same time they determine eligibility for institutional, waivered, or hospice services.

Application for NF care

Department-designated social services staff:

1. Ensure that the client has made a financial application.

2. Assess the client's functional eligibility for institutional care by completing the comprehensive assessment (CA).

3. Screen all clients to determine potential for and/or interest in home and community-based services.

4. Determine if the client is likely to attain institutional status as described in WAC 388-513-1320.

5. Notify the facility when the client doesn't appear to meet the need for NF care.

6. Determine if there is potential for relocation and what level of intervention would be required following the procedures outlined in nursing facility case management (AASA Program Manual, Chapter 5, Section 7B).

7. Provide financial services staff with the following information:

8. Date of NF admission, or date of CA request, whichever is later.

9. If the client is likely to attain institutional status.
10. The amount of housing maintenance exemption, if appropriate.

11. Authorize NF placements.

12. Arrange transfers and relocations.

13. Authorize discharge allowances.

14. Help the client with discharge planning.

Financial services staff:

1. Refer the client to the SW for a CA, if the client contacts the FSS first, and document the date the client first requested NF care.

2. Determine the client's financial eligibility for LTC services and non-institutional medical assistance.

3. Authorize payment for NF care if the client is both functionally and financially eligible. Institutional services are approved effective the date of:

   (a) Request for CA or date of financial request for benefits, whichever is earlier, or

   (b) Financial eligibility for institutional services or date of NF placement, if later than the above dates.

4. Notify the SW when the request for services is received and ensure that the SW receives a copy of the initial approval/denial notice.